Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MUHAMMAD M FAROOQI MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-3544-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 04, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested reconsideration from the insurance, Texas Mutual, for a claim on patient Catalina Soto, for date of service 11/08/2013 in the amount of $1,150.00, for a Designated Doctor Exam. We received no payment. We submitted a reconsideration request on 06/27/2014, for the entire amount. The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 11/8/13. The requestor used the DRE method to assign impairment. Texas Mutual paid the MAR for this method. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 08, 2013	CPT Code 99456-W5-WP and 99456-W6-RE	$1,150.00	$1,150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
    - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
    - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly

- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
- CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment
- CAC-18 – Exact duplicate claim/service
- 736 – Duplicate appeal. Network Contract applied by Texas Star Network. Call 1-800-381-8067 for reconsideration

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the total allowable reimbursement for the disputed services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute involves a Designated Doctor Examination for Maximum Medical Improvement and Impairment rating to the wrist, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, §134.204(j)(4)(C)(iI)(II) states If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and reimbursement for extent of injury examination per 28 Texas Administrative Code §134.204(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."
2. Review of the submitted documentation finds maximum medical improvement and impairment rating with range of motion performed to the wrist. The Division concludes that the allowable for maximum medical improvement and impairment rating is allowed for the amount of $650.00 in accordance with §134.204(j)(3)(C) and §134.204(j)(4)(C)(iI)(II).

   Review of the submitted documentation finds extent of injury examination performed. The Division concludes that the allowable for extent of injury examination is allowed in the amount of $500.00 in accordance with the requirements of §134.204(k).
3. The division concludes that the total allowable for the maximum medical improvement and extent of injury examination is $1,150.00. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $1,150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/30/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.